

**MODEL PEDIATRIC INTERFACILITY
TRANSFER AGREEMENT**

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The Model Pediatric Interfacility
Transfer Agreement Subcommittee

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MODEL PEDIATRIC INTERFACILITY TRANSFER AGREEMENT SUBCOMMITTEE

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EMERGENCY MEDICAL SERVICES FOR CHILDREN

California EMS Authority

Model Pediatric Interfacility Transfer Agreement



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Model Pediatric Interfacility Transfer Agreement



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Introduction

Organized systems of care for critically ill and injured children should include the identification of specialized referral centers for the care of these children. Systems should also include mechanisms that promote effective working relationships and linkages between referring hospitals and centers. Such linkages help to ensure that critically ill and injured children receive needed services, that appropriate consultation services are available, and that children are rapidly transported to specialized centers, when indicated.

Formal transfer agreements provide a mechanism for establishing working relationships between community hospitals and referral centers. Such agreements should establish a clear understanding of the responsibilities of the referring physicians and physicians at the center. Transfer agreements also provide a means of formalizing arrangements for consultation, transport, and education programs, including procedures that should be followed for obtaining consultation or transferring children to specialized centers.

Transfer agreements are agreements between hospitals and do not deal with medical decisions regarding whether a particular patient should be transferred or not. In addition, transfer agreements do not dictate the physician's choice as to which specific center the patient is transferred.

Organized systems of care for critically ill and injured children should include the development of written transfer agreements between community hospitals and specialized centers for the care of critically ill children and pediatric trauma patients. In some regions, a single agreement may be signed with a center that is both a Pediatric Critical Care Center (PCCC) and a Pediatric Trauma Center (PTC) although separate agreements may be necessary to clearly delineate the process of access to these two different treatment systems. In other regions, community hospitals may need to sign multiple agreements with PCCCs, PTCs, or General Trauma Center(s) (GTCs) to meet the needs of pediatric patients.

General trauma centers have the capability to manage acute trauma in all age groups and serve as major referral centers for pediatric trauma. However, they vary in terms of their capabilities to provide specialized services, such as intensive care services, for pediatric patients. GTCs that serve as referral centers for pediatric trauma, but lack a CCS-approved Pediatric Intensive Care Unit (PICU), should



establish a transfer agreement with a referral center that has a CCS-approved PICU. Agreements should include specific guidelines for consultation and transfer of pediatric patients who require services not available at the GTC.

Referring hospitals may sign agreements with any number of PCCCs, PTCs, or GTCs. Pediatric transfer agreements can be developed as separate agreements or they can be included as an addendum to a hospital's general transfer agreement with a specialized referral center. For example, transfer agreements between community hospitals and a GTC might include an addendum with special provisions for consultation and transfer of pediatric patients.

Local EMS agencies should identify specialty care centers for critically ill and injured children, including the development of standards, the evaluation of the pediatric capabilities of centers, and the designation of centers for pediatric critical illness and trauma. Centers may be within the boundaries of the local EMS agency or in a contiguous area. Local EMS agencies should include written transfer agreements between community hospitals and centers as an integral part of their system to ensure adequate access to specialized care. The attached Model Pediatric Interfacility Transfer Agreement was developed to assist PCCCs, PTCs, GTCs, and local EMS agencies to develop appropriate pediatric transfer agreements for their regions.



MODEL PEDIATRIC INTERFACILITY TRANSFER AGREEMENT

A G R E E M E N T

This AGREEMENT is made between SPECIALIZED REFERRAL CENTER (CENTER)*
LOCATED AT _____

and HOSPITAL located at _____,
_____, hence forth referred to as HOSPITAL or referring
hospital.

This Agreement serves as documentation of the arrangements, policies, and procedures governing the transfer of critically ill and/or injured pediatric patients (...Add other types of patients or services, if desired...) between the above named institutions in order to facilitate timely transfer, continuity of care, and appropriate transport for these patients.

THE CENTER AND HOSPITAL DO MUTUALLY AGREE AS FOLLOWS:

1. HOSPITAL recognizes that on certain occasions pediatric patients require specialized care and services beyond the scope of services available at HOSPITAL and that optimal care of these children requires transfer from the emergency department or inpatient services to centers with specialized pediatric critical care or pediatric trauma services.
2. The medical staff and hospital administration of HOSPITAL have identified the CENTER as a pediatric referral center with specialized staff and facilities for tertiary-level care of critically ill and/or injured children.
3. The CENTER agrees to maintain a regional (Tertiary) (1) Pediatric Critical Care Center, (2) Pediatric Trauma Center or (3) General Trauma Center that is equipped and staffed to provide a full range of pediatric medical and surgical services for critically ill pediatric patients and/or pediatric trauma patients in accordance with California Children Services (CCS) Pediatric Intensive Care Unit standards, or applicable State and local EMS Agency standards for Pediatric Critical Care Centers, Pediatric Trauma Centers, or General Trauma Centers.
4. The CENTER agrees to accept transfers of critically ill and injured pediatric patients from HOSPITAL if beds, personnel, and appropriate services are available, if the transfer has been



approved by the receiving physician, and if the transfer is consistent with current patient transfer laws.

* Specialized referral centers for pediatric critical care and/or pediatric trauma care, may include: (1) Pediatric Critical Care Center(s), (2) Pediatric Trauma Centers(s), or (3) General Trauma Center(s).

5. Pursuant to CCS requirements for regional (tertiary) level approval and State Trauma System regulations, CENTERS will provide 24-hour telephone consultation services, 24-hour pediatric transport services, and educational programs related to pediatric emergency, critical care, and/or trauma care that can be made available to community health professionals involved in such care.
6. HOSPITAL and CENTER recognize the privilege of an attending physician and the right of the patient, or the patient through a relative or guardian, to request transfer to an alternate facility.

Indications for Pediatric Transfers

7. The referring physician has examined the patient, documented the patient's condition, and has determined that the patient requires a higher level of care than provided at HOSPITAL or requires specialized services provided at the CENTER.
8. The referring physician has evaluated the patient and has determined that the transport is compatible with the patient's condition and is in the best interests of the patient's medical care.

Transfer Arrangements

9. Requests for consultation or transport team support and patient transfer can be generated by telephone to:

(List appropriate telephone numbers for pediatric critical care, trauma, transport, and other services, as appropriate.)
10. When it appears that a pediatric patient requires specialized services or medical care beyond the scope of services provided at HOSPITAL, the referring physician shall contact an appropriate specialist at the CENTER to obtain consultation. The referring physician in conjunction with the CENTER consultant shall be responsible for determining the need for admission to the CENTER.



The consent of appropriately authorized staff at the CENTER to receive the patient shall be obtained prior to the patient's release from HOSPITAL and shall be documented in the patient's medical record.

11. Transfer arrangements will be made by mutual consent of the referring and consulting physician. It shall be the responsibility of the physician to whom the patient is transferred to arrange the admission of the patient to the CENTER. If the CENTER is unable to accept the patient because of lack of physical or professional resources, the CENTER personnel will assist the referring hospital in locating an alternative center for patient placement.
12. The referring physician, in consultation with the receiving physician, shall determine the method of transport to be used. The CENTER may, at its option, provide a specially-trained pediatric transport team. The team shall be in attendance during the entire transport.
13. To the extent possible, patients will be stabilized prior to transfer and treatment initiated to ensure that the transfer will not, within reasonable medical probability, result in harm to the patient or jeopardize survival. Responsibility for the stabilization and care of patients prior to and during transport should be specified.
14. The referring hospital shall be responsible for informing the patient, patient's parent(s), legal guardian, or other relatives of the transfer process and for obtaining any release to effect the transfer. The referring hospital shall use its best efforts to arrange for the parent(s) or guardian to be present at the time of transport.
15. The referring hospital shall be responsible for the transfer or other appropriate disposition of any personal belongings of the patient.

Records and Transmission of Information

16. Subject to federal and state laws regarding consents of minors for medical care and confidentiality of medical information the referring hospital shall send with the patient, or arrange to be immediately transmitted (via FAX), at the time of transfer the necessary documents and completed forms containing the medical, social, and/or other information necessary to ensure continuity of care to the patient. Such documentation shall include at least the following:



- a. Identification of the patient
 - b. Diagnosis
 - c. Copies of the relevant portions of the patient's medical record (including medical, nursing, dietary, laboratory, X-rays, and medication records)
 - d. Relevant transport forms
 - e. Copy of signed consent for transport of a minor
17. Subject to limitations regarding confidentiality, the CENTER shall provide information on the patient's diagnosis, condition, treatment, prognosis, and any complications to the referring physician during the time that the patient is hospitalized at the CENTER and upon discharge or transfer from the CENTER.

Return of Patient to Referring Hospital

18. When the patient's physician at the CENTER determines that the patient is medically fit for return to the referring hospital, that physician should contact an appropriate physician at the referring hospital to arrange for the return of the patient. The CENTER shall send with the patient at the time of transfer the necessary documents and forms containing the medical, social, and/or other information necessary to ensure continuity of care to the patient. The CENTER shall be responsible for informing the patient, patient's parent(s) or legal guardian of the transfer process and for obtaining any releases required for the transfer or the appropriate disposition of any personal effects of the patient. The CENTER will be responsible for arranging patient transport to referring hospital.
19. The return transfer of pediatric patient for continued care upon completion of the treatment at the CENTER will be made by mutual agreement.

Charges for Services

20. Charges for services performed by either institution shall be made and collected by the institution in accordance with its regular policies and procedures. Unless special arrangements have been made to the contrary, the transfer of a patient from one institution to the other shall not be construed as imposing any financial liability by one institution on the other. The parties shall cooperate with each other in the exchange of information about financial responsibility for the services rendered by them to patients who are transferred to the CENTER.



Authority of Governing Bodies

21. The Governing Body of each institution shall have exclusive control of its policies, management, assets and affairs, and neither shall incur any responsibility by virtue of this Agreement for any debts or other financial obligations incurred by the other. Further, nothing in this Agreement shall be construed as limiting the rights of either institution to contract with any other facility on a limited or general basis.

Term of Agreement

22. The term of this Agreement shall commence on _____ and shall continue in full force and effect until _____. Either institution may terminate this Agreement at any time upon giving the other written notice not less than thirty (30) days in advance of the termination date. However, should either institution fail to maintain its license or certification, this Agreement shall automatically terminate as of the date of termination of the license or certification.

Indemnification

23. The parties agree to indemnify, defend and hold one another, their officers, agents and employees harmless from and against any and all liability, loss, expense, attorney's fees, or claims for injury or damages arising out of their performance of this Agreement, but only in proportion to and to the extent such liability, loss, expense, attorney's fees, or claims for injury or damages are caused by or result from the negligent or intentional act or omission of the indemnifying party.

Compliance with Laws and Regulations

24. This Agreement is entered into and shall be performed by both parties in compliance with local, state and federal laws, rules, regulations, and guidelines, including COBRA and OBRA.

Insurance Provisions

25. The parties hereto warrant they shall obtain and maintain during the term hereof, at their own sole cost and expense, insurance or a program of self insurance covering their activities in performance hereof.



General Provisions

26. This Agreement constitutes the entire understanding of the parties hereto with respect to the matters discussed herein and supersedes any and all written or oral agreements, representations or understandings, whether made by the parties or others purportedly on behalf of one of the parties. No changes, amendments, or alterations of this Agreement shall be effective, unless made in writing and signed by both parties.
27. It is not the intention of either party that any person or entity be a third party beneficiary of this Agreement.
28. Neither party may assign, sell, or otherwise transfer this Agreement, or any interest in it, without the express prior written approval of the other.
29. Any notice required or permitted by this Agreement shall be effective and shall be deemed delivered five (5) business days after placing it in the mail, by certified mail, return receipt requested, postage prepaid, or upon personal delivery as follows:

To: Administrator
CENTER
Address

To: Administrator
HOSPITAL
Address



IN WITNESS WHEREOF, the parties have executed this Agreement of the date written below.

HOSPITAL (Name and Address)

Chief Executive Officer

Name _____

Title _____

Date _____

Chief of Medical Staff

Chief of Pediatrics

Chief of Emergency Medicine

CENTER (Name and Address)

Chief Executive Officer

Name _____

Title _____

Date _____

Medical Director of PICU

Chief of Pediatrics

Chief of Trauma Service

Medical Director of Emergency Dept.



Suggested Readings

1. Model Pediatric Interfacility Transfer Agreement. Recommendations for a Regional Pediatric Critical Care System. Pediatric Intensive Care Network of Northern and Central California; Santa Cruz. CA: 1988.
2. Model Pediatric Interfacility Transfer Agreement. California Pediatric Critical Care Coalition; 1989.
3. Seidel, JS and Henderson, DP: Emergency Medical Services for Children, A Report to the Nation. National Center for Education in Maternal and Child Health; Washington, DC; 1991: p. 42-48.
4. Emergency Medical Services for Children: The Role of the Primary Care Provider. American Academy of Pediatrics; 1992.
5. Pediatric Interfacility Transfer Agreements developed by:
 - a) Children's Hospital, Oakland
 - b) U. C. Davis Medical Center
 - c) Sutter Memorial Hospital
 - d) Valley Children's Hospital, Fresno
 - e) Santa Clara Valley Medical Center
 - f) Stanford University Medical Center

